| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175353 | A. BUILDING _____ B. WING _____ | C 12/02/2015 |

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| **ARMA HEALTH AND REHAB** | **605 EAST MELVIN ST PO BOX 789 ARMA, KS 66712** |

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| F 000 | INITIAL COMMENTS<br><br>The following citations represent the findings of complaint investigation #93623 and #94158. | F 000 | | |
| F 241 SS=D | 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY<br><br>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.<br><br>This Requirement is not met as evidenced by:<br>The facility reported a census of 26 residents, with 3 residents sampled for dignity. Based on interview and record review, the facility failed to maintain the dignity for 1 (#4) of 3 sampled residents, by placing the resident on a mattress on the floor in a common area of the facility, frequently dressed in a hospital gown, and the resident un-dressed self while on the floor in this area.<br><br>Findings included:<br><br>- The admission minimum data set (MDS), dated 7/27/15, documented resident #4 with severely impaired cognition by staff assessment and required extensive assist of 2 staff for transfers, bed mobility, walking, and dressing. There were no falls identified prior to admission.<br><br>The quarterly MDS, dated 10/20/15, documented the resident required total dependence of staff for all ADLs (activities of daily living) and had 2 or more falls with no injury and 2 or more falls with injury, not major since the previous assessment.<br><br>The care area assessment, dated 7/27/15, documented the resident with multiple behaviors | F 241 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| F 241 | Continued From page 1<br>and high fall risk.<br><br>The care plan, dated 8/9/15, directed 1-2 staff to provide the resident assistance for bed mobility, transfers, and dressing. The care plan update, on 10/23/15, documented for safety the resident sleeps and sets on a mattress or floor mats, placed on the floor by the TV, near the nurse ' s station. The resident had very poor safety awareness and normally rests comfortable in this environment. The care plan, updated on 10/30/15, documented the resident mattress moved into the resident ' s room.<br><br>Review of the nurse ' s notes on the following dates documented several occasions of the resident lying on the mattress on the floor near the nurse ' s station and staff re-directing the resident to put his/her clothes back on, while the resident was attempting to disrobe: 10/22/15 at 12:30 AM, 10/22/115 at 10:25 PM, 10/23/15 at 10:35 PM, 10/24/15 at 5:56 AM, 10/24/15 at 3:31 PM, 10/25/15 at 10:12 AM, 10/27/15 at 2:32 PM, 10/28/15 at 5:31 PM.<br><br>On 12/1/15 at 1:12 PM, direct care staff C reported the resident stripped his/her clothes and brief off all the time. Staff used hospital gowns on the resident at times. Staff placed the resident on a mattress in the tv area on the floor for about 2 weeks, but the family really did not like that. Staff C stated the resident would get around by sliding out of bed and forcefully roll around, so staff were trying to keep him/her safe.<br><br>On 12/1/15 at 3:38 PM, administrative nursing staff B stated the resident fell frequently and would scoot off the mattress into the hall from his/her room. Staff B confirmed staff placed the resident on a mattress on the floor in the resident | F 241 | | |

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| F 241 | Continued From page 2 | F 241 | | |

' s tv area by the nurse ' s desk. Staff B stated this was a last effort to keep the resident safe because staff are always in the tv and nurse desk area. Staff B stated staff would lay on the mattress with the resident and hold his/her hand and he/she would fall asleep eventually. Staff B did not have staff 1:1 with the resident in the resident ' s room, because the area they placed the resident in (by the TV near the nurse ' s station) was a highly trafficked area by staff, it is the main nurse ' s station and that way staff could share the responsibility of watching the resident. Sometimes, the resident would strip his/her clothes off, but staff would catch him/her before they were totally off because he/she was in a high traffic area. Staff B stated the resident was on a mattress on the floor in the common area from 10/20/15 to 10/30/15. Staff B saw the resident during that time in a state of partial undress, and would have staff dress him/her.

On 12/1/15 at 2:51 PM, direct care staff D stated all residents should be dressed appropriately when out of bed. Someone had to sit 1:1 with the resident all the time. The resident required assist for dressing and transfers. Staff D stated the resident took his/her shirt off a lot regardless where he/she was in the facility.

On 12/1/15 at 3:02 PM, direct care staff E stated the resident had some behaviors of yelling and would swing at staff while providing care. He/She was a frequent faller and would just slide out of anything staff put him/her in, a bed or a chair. So, staff let her lay on a mattress by the nurse ' s desk on the floor, because he/she just needed 1:1 most of the time and this was just easier on staff for the resident to be out there rather than in the resident ' s room. The resident frequently started to take the hospital gowns off but staff

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| F 241 | Continued From page 3<br>would get it back on before he/she got completely naked.<br><br>On 12/1/15 at 3:14 PM, licensed nursing staff F stated it is his/her expectation of staff to make sure the residents are dressed appropriately and that their dignity is maintained by staff at all times. It would not be appropriate for a resident to have only a hospital gown and brief in front of other residents or visitors. Staff F stated the resident was a fall risk, very confused and combative, striking out and biting, refused care and had no safety awareness. Staff F reported to work one day and the resident was on a mattress on the floor in the living room by the tv. Staff F was told it was a safety measure to put the resident in closer proximity of staff to monitor. The resident rolled constantly to try to get to the floor and would try and disrobe. Staff F stated the situation was inappropriate, a dignity issue, and more of a convenience measure for staff than anything.<br><br>The facility provided policy for Dignity, dated October 2009, documented residents shall be treated with dignity and respect at all times. Residents shall be encouraged and assisted to dress in their own clothes rather than in hospital gowns. Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care.<br><br>The facility failed to maintain the resident in a dignified manner, as a reasonable person would expect, by placing the resident on a mattress on the floor in a common area of the facility. The resident was frequently dressed in a hospital gown, and un-dressed self while on the floor in this area. | F 241 | | |
| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING | F 309 | | |

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| F 309 | Continued From page 4<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This Requirement is not met as evidenced by:<br>The facility reported a census of 26 residents with 3 residents sampled. Based on interview and record review, the facility failed to obtain laboratory tests as ordered for 1 (#1) of the 3 residents sampled.<br><br>Findings included:<br><br>- The physician ' s order sheet, dated 11/10/15, documented resident #1 admitted to the facility on 11/2/15 with diagnoses including myelodysplastic syndrome (poorly formed or dysfunctional blood cells in the bone marrow), and anemia.<br><br>The admission minimum data set, dated 11/7/15, documented the resident ' s brief interview for mental status score of 13, indicating cognitively intact and required minimal assist of 1 staff for activities of daily living (ADLs).<br><br>The care area assessment, dated 11/7/15, for ADLs documented the resident required 1 staff assist for some ADLs, will call for assist as needed and wishes to remain as independent as possible. The resident is able to make choices about his/her care.<br><br>The Temporary Care Plan, dated 11/2/15, directed staff to provide assistance with ADLs as | F 309 | | |

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| F 309 | Continued From page 5<br>needed.<br><br>The physician ' s order, dated 11/2/15, directed staff to obtain a CBC (complete blood count - a blood test used to evaluate overall health and detect a wide range of disorders, including anemia, infection and leukemia) every 2 weeks.<br><br>The nurse ' s note, dated 11/18/15 at 2:52 PM, documented the resident with increased drowsiness. Staff notified the physician.<br><br>The nurse ' s note, dated 11/18/15 at 7:10 PM, documented the resident as lethargic and confused at this time, only able to keep his/her eyes open to voice for about 2-3 seconds at a time. Call placed to the hospital for on call physician to call the facility back.<br><br>The nurse ' s note, dated 11/18/15 at 7:39 PM documented the on-call physician directed staff to continue the oxygen. After notifying the physician of the resident's recent Methadone order (a narcotic medication used to treat pain), the physician directed staff to hold the Methadone, monitor the resident's condition, and to have the dayshift nurse to call the primary care physician tomorrow for new orders.<br><br>The nurse ' s note, dated 11/19/15 at 1:50 PM, documented the resident was admitted to the hospital and will receive 2 units of blood for a Hgb (hemoglobin - a protein in red blood cells that carries oxygen throughout the body) of 5.5 %. A call was placed to the cancer center where resident was due to have an appointment today. Staff there state that resident receives blood transfusions every 4-6 weeks regularly, due to myelodysplastic syndrome and the last PRBC (packed red blood cells) transfusion was | F 309 | | |

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| F 309 | Continued From page 6<br>administered on 10/22/15.<br><br>On 12/1/15 at 10:36 AM, Administrative Nursing Staff B reported he/she did the resident ' s admission and the facility was without a medical records person at the time. Staff B input the orders for the labs into the medical record. Staff B stated the facility used a paper calendar at the nurse ' s desk to track labs that were due and Staff B was responsible to put the order for the lab work onto the calendar, but failed to do so. This resulted in the resident ' s lab work not being drawn when it was ordered by the physician.<br><br>On 12/1/15 at 10:48 AM, the resident reported he/she had blood work done every few weeks or so. Sometimes it is done more often, other times not as often. The resident stated he/she suffered from a blood disorder and anemia for a long time now, had blood transfusions every 4 or 5 weeks, but he/she was unable to recall any dates of the transfusions. The resident recalled that prior to needing a transfusion, he/she often feels sluggish and tired, just not himself/herself.<br><br>The facility provided policy for Lab and Diagnostic Test Results, dated February 2014, documented labs will be ordered by a physician and staff will process test requisitions and arrange for tests per community and contracted lab protocol.<br><br>The facility failed to obtain lab work as ordered by the physician, to monitor the resident's anemia, and ensure the resident received treatment in a timely manner. | F 309 | | |